Assertions about patient information are not supported

EDITOR,—I am surprised at the assertion of Philip Meredith and colleagues that patients do not use information provided in printed form "nor particularly like doing so."[1] Such an assumption seems to contradict research findings over the past decade showing that patients tend to be much more satisfied with communication after they are given printed information,[2] may rate leaflets more highly as a source of information than doctors,[3] and want to receive printed information about surgical and medical interventions.

Meredith and colleagues' claim that leaflets may not be understood by "over a third of those reading them" seems to rest on studies using readability formulas. The validity and usefulness of these studies have been questioned.[4] Hawkey and Hawkey reported that a leaflet on diverticular disease with a Flesch reading ease score of 46 was rated as easy to understand by 78% of patients.[3] Ley claimed that a text with such a score would be rated as "difficult," typically "academic," and would be understood by only 31% of people aged 25 or older and only 17% of people aged 65 or older.[5] In addition, Mayberry, whom Meredith and colleagues quote, reported that patients may be highly motivated to read difficult text.

Finally, Meredith and colleagues argue that leaflets and other educational material should be developed "independently of commercial interests." Leaflets produced by clinicians, nurses, and other health professionals as a "do it yourself" project have been heavily criticised; many leaflets produced by medical charities could not be produced without commercial sponsorship and have been rated as very useful by patients.[3] Moreover, the content of leaflets produced by pharmaceutical companies in particular is tightly regulated and forbids "covert advertising for a particular product."

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Working in a developing country

Returned volunteers can advise

EDITOR,—Many of the points that Paul Johnstone discusses in relation to work in a developing country—and, indeed, the reasons for going that he puts forward—also apply to the work of the British volunteer programme.[1] The volunteer programme was founded during the 1960s by Alec Dickson through Voluntary Service Overseas.

Many of us who have been through that formative experience have felt the need for some support after our service and have also wished to go on using the enthusiasm and experience gained to benefit the Third World. For this reason the British charity Returned Volunteer Action was set up and maintains a network of local groups. These may also be of value to people thinking of working abroad, who can be put in touch with recently returned volunteers with local knowledge of conditions and needs. The benevolent instincts of would be volunteers should be nurtured but also informed. Furthermore, no one understands the "post-volunteering stress syndrome" better than those who have gone through the process (even if it was once called "reverse culture shock"). Returned Volunteer Action can be contacted at 1 Amwell Street, London EC1R 1UL (tel 0171 278 0804).

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1 Johnstone P. How to work in a developing country. *BMJ* 1995;311:113-5. (8 July.)

Structured training must allow overseas experience . . .

EDITOR,—The Calman report proposes more structured training. It is important that this should include enough flexibility for one to two years spent in a developing country to be a possible component in the training package. Review of the posts abroad and supervision by experienced doctors from Britain may make them acceptable for accreditation. I hope that the Joint Committees on Higher Medical Training and on Surgical Training, specialty groups, and the Royal College of General Practitioners will recognise the value of broader training while planning the structured models. There are still situations in which longer perids of work are possible and permit a greater contribution to local health services. Doctors intending to work abroad should build good links with empathetic general practices and consultants before they go and try to maintain the links while abroad.

What skills should doctors take and share? Paul Johnstone sums these up well, especially where he emphasises that more may be learnt than contributed.[1] Basic clinical skills still have a place, especially in Africa and areas where the secondary hospital services are often provided by charitable agencies. Teaching and training are needed everywhere and at all levels, but the emphasis must be practical rather than on the classroom. How and where these skills are to be used are also important. Some countries have many doctors, but there is serious maldistribution and still many underserved people and communities. Also, the concepts of teamwork and compassion in care are worth demonstrating.

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1 Johnstone P. How to work in a developing country. *BMJ* 1995;311:113-5. (8 July.)

. . . which is good experience

EDITOR,—Bryan Christie's news article was encouraging to doctors from Britain who work at Hlabisa Hospital in rural Zululand.[1] Many of them experienced discouragement and warnings of "career suicide" when proposing to opt out from accepted career pathways in Britain to work in the developing world for a short period.

It would be heartening if prospective employers in the NHS, whether hospital consultants, general practitioners, or managers, could appreciate the range of experience gained here, as promoted by Chris Abell and Sandra Taylor.[2] Most skills learnt here would be of considerable benefit to any part of the NHS. Irrespective of previous experience, doctors here act as sole decision makers in a wide range of medical, surgical, anaesthetic, and obstetric problems. Rather than diminishing the quality of care, this responsibility promotes an attitude of continuing learning and critical review of current practice. This is supported by daily team meetings, weekly grand rounds, and monthly journal clubs. Management of care is by protocols, which are regularly updated, and medical audit is an integral part of practice.

Of particular interest are the additional competencies learnt through dealing with extremely limited resources while caring for a very ill population. Skills include developing the most cost effective approaches to care, enhancing efficient use of resources, and managing wards and staff. Emphasis on the causes of ill health has helped people to focus on finding appropriate interventions in the community through action and research. Many of the doctors are now competent in research techniques and practical computer skills. As the Princess Royal states, they have a greater all round competence than if they had stayed at home for the same time.[1]

What the NHS gains from their return is confident and highly competent doctors who can approach their medical work with enthusiasm while retaining a critical awareness about providing appropriate and cost effective care. They do not fear innovation but recognise that there are many different ways to approach complex problems. The managerial skills developed would be hard to equal in many management training courses for senior registrars or half day release courses for general practitioners. In these times of hardship for the NHS such abilities should not be wilfully ignored but encouraged and fostered. Sharing skills with the developing world is not a one way process: both sides can gain.

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2 Abell C, Taylor S. The NHS benefits from doctors working abroad. *BMJ* 1995;311:133-4. (8 July.)

Anaesthesia on board charity ship staves off burnout

EDITOR,—Bryan Christie reports that the Princess Royal advocates that NHS staff should work in the developing world.[1] I am a consultant anaesthetist who since 1991 has spent three weeks each year anaesthetising patients for ophthalmic and maxillofacial surgery on board the ship *Anastasis* off west Africa. My enlightened employers permit me to take this extra time away as a combination of continuing medical education and unpaid leave. My former employers at Heatherwood and Wexham Park Hospitals Trust allowed me the three extra weeks on full pay for one extra fixed session a week.

The *Anastasis* is a 152 m long, 12 200 tonne converted cruise liner, which has been fitted with three operating theatres and a 30 bed ward. She spends five months each year off west Africa. Medically trained volunteers, who finance themselves, are accepted for a minimum of two weeks—an insignificant time out of one's own lifetime but not to the needy people whose lives may be irrevocably changed by surgery performed on a big white ship whose name is Greek for "Resurrection."

The benefits of allowing staff the opportunity of undertaking this work may not be immediately obvious to managers, who might well require something in return for granting the privilege of extra leave. Staff who face such attitudes should consider that, while the benefit from helping people in the Third World cannot be measured financially, it is evident in terms of personal development and increased clinical experience. I return with a greatly increased zest for life, decreased risk of "executive burnout," more